code the responses as information not available (-). If the resident appears content during an activity (e.g., smiling, clapping during a music program), check the item on the form.

N5. Prefers Change in Daily Routine (7-day look back)

Intent: To determine if the resident has an interest in pursuing activities not offered at the facility (or on the nursing unit), or not made available to the resident. This includes situations in which an activity is provided but the resident would like to have other choices in carrying out the activity (e.g., the resident would like to watch the news on TV rather than the game shows and soap operas preferred by the majority of residents; or the resident would like a Methodist service rather than the Baptist service provided for the majority of residents). Residents who resist attendance/involvement in activities offered at the facility are also included in this category in order to determine possible reasons for their lack of involvement.

Process: Review how the resident spends the day. Ask the resident if there are things he or she would enjoy doing (or used to enjoy doing) that are not currently available or, if available, are not "right" for him or her in their current format. If the resident is unable to answer, ask the same question of a close family member, friend, activity professional, or nurse assistant. Would the resident prefer slight or major changes in daily routines, or is everything OK?

Coding: For each of the items, code for the resident's preferences in daily routines using the codes provided.

0. No Change - Resident is content with current activity routines.

1. Slight Change - Resident is content overall but would prefer minor changes in routine (e.g., a new activity, modification of a current activity).

2. Major Change - Resident feels bored, restless, isolated, or discontent with daily activities or resident feels too involved in certain activities, and would prefer a significant change in routine.

Example

Mrs. B is regularly involved in several small group activities. She also has expressed a preference for music. However, she has consistently refused to go to group sing-alongs when the activity staff offers to bring her. She says she doesn't like big groups and prefers to relax and listen to classical music in her room. She wishes she had a radio or tape player to do this.

		Code
a.	**Type of activities in which resident is currently involved**	1 (Slight change)
b.	**Extent of resident involvement in activities**	1 (Slight change)

SECTION O. MEDICATIONS

O1. Number of Medications (7-day look back)

Intent: To determine the number of different medications (over-the-counter and prescription drugs) the resident has received in the past seven days.

Process: Count the number of different medications (not the number of doses or different dosages) administered by any route (e.g., oral, IV, injections, patch) at any time during the last seven days. Include any routine, prn, and stat doses given. "Medications" include topical preparations, ointments, creams used in wound care (e.g., Elase), eyedrops, vitamins, and suppositories. Include any medication that the resident administers to self, if known. If the resident takes both the generic and brand name of a single drug, count as only one medication. For example, if the resident received a long-acting antipsychotic medication prior to the assessment period (e.g., if a fluphenazine deconoate or haloperidol deconoate is given once a month), count as one drug.

Coding: Write the appropriate number in the answer box. Count only those medications actually administered and received by the resident over the last seven days. Do not count medications ordered but not given.

Clarifications:

- If a dietary supplement, given to a resident between meals, has a vitamin as one of its ingredients, code it as a dietary supplement, *not* as a medication.

  Coding Examples:

  - If a resident receives a daily Vitamin C capsule, add it to the medication count in number of medications (O1).

  - If a resident receives a dietary supplement between meals and the label contents specify that Vitamin C (or any other vitamin, etc) is one of the ingredients, code (K5f = check) for dietary supplement between meals.

  - The basic TPN solution itself (that is, the protein/carbohydrate mixture or a fat emulsion) is not counted as a medication. The use of TPN is coded in Section K., Oral Nutritional Status. Medications, such as electrolytes, vitamins, or insulin, which have been added to the TPN solution, are considered medications and should be coded in this section.

- Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). They are not regulated by the FDA (e.g., they are not reviewed for safety and effectiveness like medications) and their composition is not standardized (e.g., the composition varies among manufacturers). Therefore, they should not be counted in this item. These substances may be coded at MDS Item K5f, provided they meet the definition of dietary supplement for this Item. Keep in mind that, for clinical purposes, it is important to document a resident's intake of such substances elsewhere in the clinical record and to monitor their potential effects, as they can interact with other medications. More information on dietary supplements identified by the FDA can be found at the following web site: **http://www.nih.gov/health.**

- All medications used by the resident in the 7-Day assessment period need to be counted in Section O. All medications administered off-site (e.g., while receiving dialysis or chemotherapy) must be considered when completing this item. The facility is responsible for communicating with the outpatient site to identify the use of any medications received while the resident was under their care, and for monitoring the effect, including any adverse effects, of medications after the resident's return to the facility.

- Combination products such as Corzide (which contains a diuretic and a beta-blocker) are counted as one medication.

- Administration of Epogen should be recorded in several places in Section O, depending on its route of administration and date of initiation. It should be counted at MDS Item O1 (Number of Medications), and if it was initiated during the last 90 days, it should also be indicated at MDS Item O2 (New

Medication). If the Epogen was given subcutaneously, also record it in Item O3 (Injections). If it is given intravenously, it should be indicated at MDS Item P1ac (IV medication).

- Heparin included in a saline solution used to irrigate a "heparin lock" is not counted in this item.

- Each type of insulin that a resident receives should be counted separately. For example, Lente, Neutral Protamine Hagedorn (NPH), and Regular are different types of insulin and are considered different medications.

- Ensure or any nutritional supplement is not counted as a medication for coding in Section O. The dietary supplement could be recorded in Section K5f, provided it fits the definitions.

- If the resident received an injection of Vitamin B12 prior to the observation period, code in Item O1. Vitamin B12 maintains a blood level, as do long acting antipsychotics. Do not code Vitamin B12 injections in Item 03 (Injections) if it was given outside of the observation period.

- Record suppositories in Item O1, Number of Medications. For facilities in states using Section U, also record in Section U.

Example

Resident was given Digoxin 0.25 mg po on Tuesday and Thursday and Digoxin 0.125 mg po on Monday, Wednesday, and Friday. Although the dosage is different for different days of the week, the medication is the same. **Code "1" (one medication received).**

O2. New Medications (90-day look back)

Intent: To record whether or not the resident is currently receiving medications that were initiated in the last 90 days.

Coding: Code "**1**" if the resident received (and continues to receive) new medications in the last 90 days. Code "**0**" if the resident did not receive any new medications in the past 90 days. If the resident received new medication(s) in the last 90 days but they were discontinued prior to this assessment period, code "0" (no new medication).

O3. Injections (7-day look back)

Intent: To determine the number of days during the past seven days that the resident received any type of medication, antigen, vaccine, by subcutaneous, intramuscular or intradermal injection. Although antigens and vaccines are

considered "biologicals" and not medication per se, it is important to track when they are given to monitor for localized or systemic reactions. This category does not include intravenous (IV) fluids or medications. If the resident received IV fluids, record in Item K5a, Parenteral/IV. If IV medications were given, record in Item P1ac, IV medications.

Coding: Record the number of DAYS in the answer box.

Clarifications:

- There is no item for insulin pumps on the current MDS. You would code the MDS as follows:

  O1 - Count the insulin as a medication;
  O2 - Identify if this was a new medication or not;
  O3 - Code **only** the number of days that the resident actually required a subcutaneous injection to restart the pump.

- A Subcutaneous Computer Assisted Dispatch (CAD) pump would be coded as an injection in this item.

- If a test or vaccination is provided on one day and another vaccine provided on the next day, code "2" for the number of days when the resident received injections. If both injections were administered on the same day, code "1". Also include these medications when coding Item O1.

Example

During the last 7 days, Mr. T received a flu shot on Monday, a PPD test (for tuberculosis) on Tuesday, a Vitamin B_{12} injection on Wednesday. **Code "3" for Resident received injections on three days during the last seven days**.

During the last 7 days, Miss C received a flu shot and her vitamin B_{12} injection on Thursday. **Code "1" for resident received 2 injections on the same day in the last 7 days.**

O4. Days Received the Following Medication (7-day look back)

Intent: To record the number of days that the resident received each type of medication listed (antipsychotics, antianxiety, antidepressants, hypnotics, diuretics) in the past seven days. See Appendix E for list of drugs by category. Includes any of these medications given to the resident by any route (po, IM, or IV) in any setting (e.g., at the nursing facility, in a hospital emergency room).

Process: Review the resident's clinical record for documentation that a medication was received by the resident during the past seven days. In the case of a new admission, review transmittal records.

Coding: Enter the number of days each of the listed types of medications was received by the resident during the past seven days. In the case of a new admission, if it is clearly documented that the resident received any type of medication (listed in this item) at the sending facility, record the number of days each listed medication was received during the past seven days. If transmittal records are not clear or do not reference that the resident received one of these medications, record "**0**" (not used) in the corresponding box. If the resident did not use any medications from a drug category, enter "**0**". If the resident uses long-lasting drugs that are taken less often than weekly (e.g., Prolixin (Fluphenazine deconoate) or Haldol (Haloperidol deconoate) given every few weeks or monthly) enter "**1**".

a. Antipsychotic

b. Antianxiety

c. Antidepressant

d. Hypnotic

e. Diuretic

Clarification:

- Code medications according to a drug's pharmacological classification, not how it is used. For example, Oxazepan (Serax) may be used as a hypnotic, but it is classified as an antianxiety. Serax would be coded as an antianxiety. Over-the-counter sleeping medications are not coded in this item, as they are not classified as hypnotic drugs.

Example 1

Medication Record for Mrs. P

- Haldol 0.5 mg po BID p.r.n.: Received once a day on Monday, Wednesday, and Thursday [Note: Haldol = Antipsychotic drug]
- Ativan 1 mg po QAM: Received every day [Note: Ativan = Antianxiety drug]
- Restoril 15 mg po QHS p.r.n.: Received at H.S. on Tuesday and Wednesday only [Note: Restoril = Hypnotic]
- Mrs. P became severely short of breath in the middle of the night during the last seven days. She was transferred (but not admitted) to the emergency room (ER) at the local hospital. Upon her return to the nursing facility the ER transmittal record stated that she had received 1 dose of IV Lasix [Note: Lasix = Diuretic].

Coding

Medication	**No. of days received**
a. Antipsychotic:	"3" (days)
b. Antianxiety:	"7" (days)
c. Antidepressant:	"0" (days)
d. Hypnotic:	"2" (days)
e. Diuretic:	"1" (days)

Example 2

Mr. S was admitted to the nursing facility on 9/12/02 (Date of Entry) from an acute care hospital. The clinical staff established that 9/16/02 would be the MDS Assessment Reference Date (last day of MDS observation period). By establishing 9/16/02 as the reference date, the observation period of 7 days extended back to 9/10/02 when Mr. S was still in the hospital. His hospital discharge summary mentioned that Mr. S was started on a daily dose of Prozac (an antidepressant) on 8/20. The hospital discharge summary was too sketchy to accurately determine if Mr. S received other medications during his hospital stay. Since admission to the nursing facility Mr. S continues to receive the same dose of Prozac.

Coding

Medication	**No. of days received**
a. Antipsychotic:	"0" (days)
b. Antianxiety:	"0" (days)
c. Antidepressant:	"7" (days)
d. Hypnotic:	"0" (days)
e. Diuretic:	"0" (days)

SECTION P.
SPECIAL TREATMENTS AND PROCEDURES

P1. Special Treatments, Procedures, and Programs

Intent: To identify any special treatments, therapies, or programs that the resident received in the specified time period. **Do not code services that were provided solely in conjunction with a surgical procedure, and the immediate post-operative recovery period.**

a. SPECIAL CARE (14-day look back)

TREATMENTS - The following treatments may be received by a nursing facility resident either at the facility, as a hospital outpatient, or inpatient basis, etc. Check the appropriate MDS item regardless of where the resident received the treatment.

Definition:

a. Chemotherapy - Includes any type of chemotherapy (anticancer drug) given by any route. The drugs coded here are those actually used for cancer treatment. For example, Megace (megestrol ascetate) is classified in the Physician's Desk Reference (PDR) as an anti-neoplastic drug. One of its side effects is appetite stimulation and weight gain. If Megace is being given only for appetite stimulation, do not code it as chemotherapy in this item. The resident is not receiving chemotherapy in these situations. Each drug should be evaluated to determine its reason for use before coding it here.

b. Dialysis - Includes peritoneal or renal dialysis that occurs at the nursing facility or at another facility. Record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH) and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medications, and blood transfusions in conjunction with dialysis are not coded under the respective items K5a (parenteral/IV), P1ac (IV medications) and P1ak (transfusions).

c. IV Medication - Includes any drug or biological (e.g., contrast material) given by intravenous push or drip through a central or peripheral port. Does not include a saline or heparin flush to keep a heparin lock patent, or IV fluids without medication. Record the use of an epidural pump in this item. Epidurals, intrathecal, and baclofen pumps may be coded, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance.

d. Intake/Output - The measurement and evaluation of all fluids the resident received and/or excreted for at least three consecutive shifts (i.e., 24 hours).

e. Monitoring Acute Medical Condition - Includes observation by a licensed nurse for ANY acute physical or psychiatric illness. Note that this is a determination regarding the resident's clinical status. Payer source is not a factor.

f. Ostomy Care - This item refers only to care that requires nursing assistance. Includes both ostomies used for intake and excretion. Do not include tracheostomy care. Code tracheostomy care by checking Item P1aj.

g. Oxygen Therapy - Includes continuous or intermittent oxygen via mask, cannula, etc. (does not include hyperbaric oxygen for wound therapy).

h. Radiation - Includes radiation therapy or having a radiation implant.

i. Suctioning - Includes nasopharyngeal or tracheal aspiration **only**. Oral suctioning should **not** be coded here.

j. Tracheostomy Care - Includes cleansing of tracheostomy and cannula.

k. Transfusions - Includes transfusions of blood or any blood products (e.g., platelets), which are administered directly into the bloodstream.

l. Ventilator or Respirator - Assures adequate ventilation in residents who are, or who may become, unable to support their own respiration. Includes any type of electrically or pneumatically powered closed system mechanical ventilatory support devices. Any resident who was in the process of being weaned off of the ventilator or respirator in the last 14 days should be coded under this definition. Does not include Continuous Positive Airway Pressure (CPAP) or Bi-level Positive Airway Pressure (BIPAP) devices.

PROGRAMS - The following programs refer to those received within a nursing facility ONLY.

m. Alcohol/Drug Treatment Program - A comprehensive interdisciplinary program within an entire or contiguous unit, wing, or floor where interventions are designed specifically for the treatment of alcohol or drug addictions.

n. Alzheimer's/Dementia Special Care Unit - Any identifiable part of the nursing facility, such as an entire or a contiguous unit, wing, or floor where staffing patterns and resident care interventions are designed specifically for cognitively impaired residents who may or may not have a specific diagnosis of Alzheimer's disease.

o. Hospice Care - The resident is identified as being in a program for terminally ill persons where services are necessary for the palliation and management of terminal illness and related conditions. This program may or may not be covered by the Medicare hospice benefit.

p. Pediatric Unit - Any identifiable part of the nursing facility, such as an entire or contiguous unit or wing where staffing patterns and resident care interventions are designed specifically for persons aged 22 or younger.

q. Respite Care - Resident's care program involves a short-term stay in the facility for the purpose of providing relief to a nursing facility-eligible resident's primary home based caregiver(s). Following this planned short stay, it is anticipated that the resident will return to his or her home in the community.

r. Training in Skills Required to Return to the Community - Resident is regularly involved in individual or group activities with a licensed skilled professional to attain goals necessary for community living (e.g., medication management, housework, shopping, using transportation, activities of daily living). May include training family or other caregivers.

s. ***NONE OF ABOVE***

Process: Review the resident's clinical record.

Coding: Check all treatments and procedures that were received during the last 14 days. If no items apply in the last 14 days, check *NONE OF ABOVE*.

Clarifications:

- Residents with sleep apnea may undergo treatments with a mask-like device that is being used to keep the airway open during sleep. This service cannot be coded as a ventilator or a respirator. According to the American Academy of Otolaryngology-Head and Neck Surgery, Inc., a CPAP (Continuous Positive Airway Pressure) device delivers air into your airway through a specially designed mask or pillows. The mask does not breathe for you; the flow of air creates enough pressure when you inhale to keep your airway open. Ventilators are sometimes used to deliver this type of non-invasive ventilation when CPAP or BIPAP machines are not available. In these cases, the ventilator is merely providing air, not traditional life support via invasive measures and does not require the same level of intensity of care that life support ventilation demands.

- Do not code services that were provided solely in conjunction with a surgical procedure, such as IV medications or ventilators. Surgical procedures include routine pre and post-operative procedures.

b. THERAPIES (7-day look back)

Therapies that occurred after admission/readmission to the nursing facility, were ordered by a physician, and were performed by a qualified therapist (i.e., one who meets State credentialing requirements or in some instances, under such a person's direct supervision).

Nursing administration, in conjunction with the physician and licensed therapist, is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided to residents. Includes **only** medically necessary therapies furnished after admission to the nursing facility. Also includes **only** therapies ordered by a physician, based on a therapist's assessment and treatment plan that is documented in the resident's clinical record. The therapy treatment may occur either inside or outside the facility.

Intent: To record the **(A) number of days**, and **(B) total number of minutes** each of the following therapies was administered to residents (for at least 15 minutes a day) in the last 7 days.

Definition:

a. Speech-Language Pathology, Audiology Services - Services that are provided by a licensed speech-language pathologist.

b. Occupational Therapy - Therapy services that are provided or directly supervised by a licensed occupational therapist. A qualified occupational therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include services provided by a qualified occupational therapy assistant who is employed by (or under contract to) the nursing facility only if he or she is under the direction of a licensed occupational therapist.

c. Physical Therapy - Therapy services that are provided or directly supervised by a licensed physical therapist. A qualified physical therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include service provided by a qualified physical therapy assistant who is employed by (or under contract to) the nursing facility only if he or she is under the direction of a licensed physical therapist.

d. Respiratory Therapy – Therapy services that are provided by a qualified professional (respiratory therapists, trained nurse). Included treatments are coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds, and mechanical ventilation, etc., which must be provided by a qualified professional (i.e., trained nurse, respiratory therapist). Does not include hand held medication dispensers. Count only the time that the qualified professional spends with the resident. (See clarification below defining "trained nurse.")

e. Psychological Therapy - Therapy provided only by any licensed mental health professional, such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker. Psychiatric nurses usually have a Masters degree and/or certification from the American Nurses Association. Psychiatric Technicians are not considered to be licensed mental health professionals and their services may not be counted in this item. If the State does not license a certain category of professionals working in your facility, you may not count the services of those unlicensed therapists in this item.

Process: Review the resident's clinical record and consult with each of the qualified therapists.

Coding: **Box A:** In the first column, enter the number (#) of days the therapy was administered for 15 minutes or more in the last seven calendar days. Enter "0" if none.

Box B: In the second column, enter the total number (#) of minutes the particular therapy was provided in the last seven days, even if you entered "0" in Box A (e.g., less than 15 minutes of therapy provided). The time should include only the actual treatment time (not time waiting or writing reports). Enter "0" if none.

A therapist's initial evaluation time may not be counted, but subsequent evaluations, conducted as part of the treatment process, may be counted.

Clarifications: **Coding Minutes of Therapy:**

- Includes only therapies that were provided once the individual is actually living/being cared for at the facility. Do NOT include therapies that occurred while the person was an inpatient at a hospital or recuperative/rehabilitation center or other nursing facility, or a recipient of home care or community-based services. If a resident returns from a hospital stay and a readmission assessment is done, count only those therapies that occurred since readmission to the facility.

- If a whirlpool treatment is specifically ordered by a physician to be performed by or under the supervision of a physical therapist, it may be coded as therapy.

- Transdermal Wound Stimulation (TEWS) treatment for wounds can be coded in Item P1b when complex wound care procedures, requiring the specialized skills of a licensed therapist, are ordered by a physician. However, routine wound care, such as applying/changing dressings, should not be coded as therapy, even when performed by therapists.

- Qualified professionals for the delivery of respiratory services include "**trained nurses**." A trained nurse refers to a nurse who received specific

training on the administration of respiratory treatments and procedures. This training may have been provided at the facility during a previous work experience or as part of an academic program. Nurses do not necessarily learn these procedures as part of their formal nurse training programs.

- The MDS instructions clearly require reporting the actual minutes of therapy received by the resident.

  - The resident's treatment time starts when he/she begins the first treatment activity or task and ends when he/she finishes with the last apparatus and the treatment is ended.

  - The time required to adjust equipment or otherwise prepare for the individualized therapy of a particular resident, is the set-up time and may be included in the count of minutes of therapy delivered to the resident.

  - The therapist's time spent on documentation or on initial evaluation may not be included.

  - Time spent on periodic reevaluations conducted during the course of a therapy treatment may be included.

  - Services provided at the request of the resident or family that are not medically necessary (sometimes referred to as a family-funded services) may not be counted in Item P1b, even when performed by a licensed therapist.

- Historically, units of therapy time have been used for billing and have been derived from the actual therapy minutes. For MDS reporting purposes, conversion from units to minutes is not appropriate and the actual minutes are the only appropriate measures that can be counted for completion of Item P1b. Please note that therapy logs are not an MDS requirement, but reflect a standard clinical practice expected of all therapy professionals. These therapy logs may be used to verify the provision of therapy services in accordance with the plan of care and to validate information reported on the MDS assessment.

- Facilities may elect to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In these situations, the services may not be coded as therapy in Item P1b, since the specific interventions would be considered restorative nursing services when performed by nurses or aides.

- A licensed therapist starts work directly with one resident beginning a specific task. Once the resident can proceed with supervision, the licensed therapist works directly with a second resident to get him/her started on a

different task, while continuing to supervise the first resident. The treatment ends for each resident 30 minutes after it begins. For each session, record 30 minutes therapy time for each resident at Item P1bB.

- In some cases, the resident will be able to perform part of the treatment tasks with supervision, once set up appropriately. Time supervising the resident is a part of total treatment time. For example, as the last treatment task of the day, a resident uses an exercise bicycle for 10 minutes. It may take the therapist 2 minutes to set the resident up on the apparatus. The therapist or assistant, under the supervision of a PT, may then leave the resident to help another resident in the same exercise room. However, the therapist still has eye contact with the resident and is providing supervision, verbal encouragement and direction to the resident on the bicycle. Therefore, if it took 2 minutes to set the resident up with the cycling apparatus, the resident was supervised during two 5-minute cycling periods; one 2-minute rest between the exercise periods; and took 1 minute to get out of the apparatus, the total cycling activity is 15 minutes. Include in this example that the resident did three additional treatment activities totaling 45 minutes before beginning to cycle. The total time reported on the MDS assessment is 60 minutes. The key is that the resident was receiving treatment the entire time and had the physical presence of a therapist in the room, supervising the entire treatment process.

- Two licensed therapists, each from a different discipline, begin treating one resident at the same time. The treatment ends 30 minutes after it starts. For each session, record 30 minutes total therapy time for the resident at Item P1bB. Split the time between the two disciplines as appropriate. For example, PT = 20 minutes, OT = 10 minutes; or PT = 15 minutes, OT = 15 minutes, etc. In the first example, where the beneficiary received 20 minutes of PT and only 10 minutes of OT, for each session code 1 day of PT at Item P1bA, and 20 minutes of PT at Item P1bB. Also code the 10 minutes of OT in Item P1bB. In this example, no days may be coded for OT at Item P1bA, because the sessions only lasted 10 minutes.

Group Therapy:

- For the most part, it is assumed that services coded on the MDS are individualized treatments, and the category does not include services received as part of a group of more than 4 residents per supervising helper. For groups of four or fewer residents per supervising therapist (or assistant), each resident is coded as having received the full time in the therapy session. For example, if a therapist worked with three residents for 45 minutes on training to return to the community, each resident received 45 minutes of therapy so long as that does not exceed 25% of his/her therapy time per therapy discipline, during the 7-day observation period. Remember, code for the resident's time, not for the therapist's time.

Example: A licensed therapist works directly with 2 - 4 residents where each resident is performing the same modality, e.g., upper body strengthening. The treatment ends 30 minutes after it starts. For each session, record 30 minutes of therapy time for each resident at Item P1bB. A maximum of 25% of the resident's therapy time can be delivered in groups.

Supervision:

- Aides cannot independently provide a skilled service. The services of aides performing therapy treatments may only be coded when the services are performed under line of sight supervision by a licensed therapist. This type of coordination between the licensed therapist and therapy aide under the direct, personal (e.g., line of sight) supervision of the therapist is considered individual therapy for counting minutes. When the therapist starts the session and delegates the performance of the therapy treatment to a therapy aide, while maintaining direct line of sight supervision, the total number of minutes of the therapy session may be coded as therapy minutes.

Maintenance Therapy/Nursing Rehabilitation:

- Once the licensed therapist has designed a maintenance program and discharged the resident from the rehabilitation (i.e., skilled) therapy program, the services performed by the therapist and the aide should no longer be reported at Item P1b as skilled therapy. The services of the aide may be reported on the MDS assessment as restorative nursing at Item P3, provided they meet the requirements for restorative therapy.

- There may be situations where nursing staff request assistance from a licensed therapist to evaluate the restorative nursing aides or to recommend changes to a restorative nursing program. Consultation with nursing staff and staff training are certainly good clinical practice. The therapist's time cannot be reported as skilled therapy in Item P3.

Example

Following a stroke Mrs. F was admitted to the nursing facility in stable condition for rehabilitation therapies. Since admission she has been receiving speech therapy twice weekly for 30-minute sessions, occupational therapy twice weekly for 30-minute sessions, and physical therapy twice a day (30 minute sessions) for 5 days and respiratory therapy for 10 minutes per day on each of the last 7 days. During the last seven days Mrs. F has participated in all of her scheduled sessions.

Coding	A	B
a. Speech-language pathology, audiology services	2	60
b. Occupational therapy	2	60
c. Physical therapy	5	300
d. Respiratory therapy	0	70
e. Psychological therapy	0	0

P2. Intervention Programs for Mood, Behavior, Cognitive Loss
(7-day look back)

Definition:

a. Special Behavior Symptom Evaluation Program - A program of ongoing, comprehensive, interdisciplinary evaluation of behavioral symptoms (such as the symptoms described in Item E4). The purpose of such a program is to attempt to understand the "meaning" behind the resident's behavioral symptoms in relation to the resident's health and functional status, and social and physical environment. The ultimate goal of the evaluation is to develop and implement a plan of care that serves to reduce distressing symptoms.

b. Evaluation by a Licensed Mental Health Specialist in the Last 90 Days - An assessment of a mood, behavior disorder, or other mental health problem by a qualified clinical professional such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker, depending on State practice acts. Do not code this item for routine visits by the facility social worker. Evaluation may take place at the nursing facility, private office, clinic, community mental health center, etc.

Each state **licenses** independent providers of mental health services who can provide care in the facility, at home, office or clinic. The term "psychiatric social worker," (synonymous with clinical social worker) refers to someone with training in clinical mental health practice that is qualified to practice as a psychotherapist. Depending on State licensure requirements, a psychiatric/clinical social worker functions as an independent practitioner or under consultation, usually to a psychiatrist.

c. Group Therapy - Resident regularly attends sessions at least weekly. Therapy is aimed at helping to reduce loneliness, isolation, and the sense that one's problems are unique and difficult to solve. The session may take place either at the nursing facility (e.g., support group run by the facility's social worker) or outside the facility (e.g., group program at community mental health center, Alcoholics Anonymous meeting at a local church, Parkinson's Disease support group at local hospital). This item does not include group recreational or leisure activities.

d. Resident-Specific Deliberate Changes in the Environment to Address Mood/Behavior/Cognitive Patterns - Adaptation of the milieu focused on the resident's individual mood/behavior/cognitive pattern. Examples include placing a banner labeled "wet paint" across a closet door to keep the resident from repetitively emptying all the clothes out of the closet, or placing a bureau of old clothes in an alcove along a corridor to provide diversionary "props" for a resident who frequently stops wandering to rummage. The latter diverts the resident from rummaging through belongings in other residents' rooms along the way.

e. Reorientation - Individual or group sessions that aim to reduce disorientation in confused residents. Includes environmental cueing in which all staff involved with the resident provides orienting information and reminders.

f. ***NONE OF ABOVE***

Process: Review the resident's clinical record for documentation of intervention programs. These interventions also should be documented in the care plan.

Coding: Check all that apply. If none apply, check *NONE OF ABOVE*.

P3. Nursing Rehabilitation/Restorative Care (7-day look back)

Intent: To determine the extent to which the resident receives nursing rehabilitation or restorative services from other than specialized therapy staff (e.g., occupational therapist, physical therapist, etc.). Rehabilitative or restorative care refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as is possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy. A resident may also be started on a restorative program when he/she is admitted to the facility with restorative needs, but is not a candidate for formalized rehabilitation therapy, or when a restorative need arises during the course of a custodial stay. Restorative nursing does not require a physician's order.

Skill practice in such activities as walking and mobility, dressing and grooming, eating and swallowing, transferring, amputation care, and communication can improve or maintain function in physical abilities and ADLs and prevent further impairment.

Definition: **Rehabilitation/Restorative Care** - Included are nursing interventions that assist or promote the resident's ability to attain his or her maximum functional potential. This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in Item P1b. In addition, **to be included in this section, a rehabilitation or restorative care must meet all of the following additional criteria:**

- Measurable objectives and interventions must be documented in the care plan and in the clinical record.
- Evidence of periodic evaluation by licensed nurse must be present in the clinical record.
- Nurse assistants/aides must be trained in the techniques that promote resident involvement in the activity.
- These activities are carried out or supervised by members of the nursing staff. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents.
- This category does not include exercise groups with more than four residents per supervising helper or caregiver.

a. Range of Motion (Passive) - The extent to which, or the limits between which, a part of the body can be moved around a fixed point or joint. Range of motion exercise is a program of passive or active movements to maintain flexibility and useful motion in the joints of the body. The caregiver moves the body part around a fixed point or joint through the resident's available range of motion. The resident provides no assistance. These exercises must be planned, scheduled and documented in the clinical record. Helping a resident get dressed does not, in and of itself, constitute a range of motion exercise session.

b. Range of Motion (Active) - Exercises performed by a resident, with cueing or supervision by staff, that are planned, scheduled, and documented in the clinical record. When residents do most of the modality, but need some assistance with the final stretch, it is still considered active range of motion.

c. Splint or Brace Assistance - Assistance can be of 2 types: 1) where staff provide verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint, or 2) where staff

have a scheduled program of applying and removing a splint or brace, assess the resident's skin and circulation under the device, and reposition the limb in correct alignment. These sessions are planned, scheduled, and documented in the clinical record.

TRAINING AND SKILL PRACTICE IN: - Activities including repetition, physical or verbal cueing, and task segmentation provided by any staff member or volunteer under the supervision of a licensed nurse.

d. Bed Mobility - Activities used to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side, and positioning him or herself in bed.

e. Transfer - Activities used to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices.

f. Walking - Activities used to improve or maintain the resident's self-performance in walking, with or without assistive devices.

g. Dressing or Grooming - Activities used to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.

h. Eating or Swallowing - Activities used to improve or maintain the resident's self-performance in feeding one's self food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth.

i. Amputation/Prosthesis Care - Activities used to improve or maintain the resident's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket).

j. Communication - Activities used to improve or maintain the resident's self-performance in using newly acquired functional communication skills or assisting the resident in using residual communication skills and adaptive devices.

k. Other - Any other activities used to improve or maintain the resident's self-performance in functioning. This includes, but is not limited to, teaching self-care for diabetic management, self-administration of medications, ostomy care, and cardiac rehabilitation.

Process: Review the clinical record and the current care plan. Consult with facility staff. Look for rehabilitation/restorative care schedule, and implementation record sheet on the nursing unit.

Coding: For the last seven days, enter the number of days on which the technique, procedure, or activity was practiced for a total of at least 15 minutes during the 24-hour period. The time provided for Items P1a-k must be coded separately, in time blocks of 15 minutes or more. For example, to check Item P3a, 15 or more minutes of PROM must have been provided during a 24-hour period in the last 7 days. The 15 minutes of time in a day may be totaled across 24 hours (e.g., 10 minutes on the day shift plus 5 minutes on the evening shift) however; 15-minute time increments cannot be obtained by combining P3a, P3b, and P3c. Remember that persons with dementia learn skills best through repetition that occurs multiple times per day. Review for each activity throughout the 24-hour period. Enter zero "0" if none.

Clarifications:

- If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this "reassessment" should be documented in the record.

- When not contraindicated by State practice act provisions, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established.

- Facilities may elect to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In these situations, the services **may not** be coded as therapy in Item P1b, since the specific interventions are considered restorative nursing services when performed by nurses or aides. The therapist's time actually providing the maintenance service can be included when counting restorative nursing minutes. Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs.

- Active or passive movement by a resident that is incidental to dressing, bathing, etc. does not count as part of a formal restorative care program. For inclusion in this section, active or passive range of motion must be a component of an individualized program with measurable objectives and periodic evaluation delivered by staff specifically trained in the procedures.

- The use of Continuous Passive Motion (CPM) devices as Rehabilitation/Restorative Nursing is coded when the following criteria are met. The CPM devices are recommended by the physical therapist and ordered by the resident's physician. Physical therapy staff may demonstrate application and use of the device to the nursing staff. The device is usually set up in the evening by the nursing staff. Monitoring of the device during the night, and documentation of the application of the device and effects on the resident are done by the nursing staff.

If the application and monitoring of the CPM device takes at least 15 minutes (or more) per day, then the nursing staff may enter the number of *days* in restorative nursing. If the application and monitoring of the CPM device takes less than 15 minutes per day, MDS Item P3a would be coded as "0".

- Grooming programs, including programs to help residents learn to apply make-up, may be considered restorative nursing programs when conducted by a member of the activity staff. These grooming programs would need to have goals, objectives and documentation of progress included in the clinical record.

Examples of Nursing Rehabilitation/Restoration

Mr. V has lost range of motion (ROM) in his right arm, wrist and hand due to a CVA experienced several years ago. He has moderate to severe loss of cognitive decision-making skills and memory. To avoid further ROM loss and contractures to his right arm, the occupational therapist fabricated a right resting hand splint and instructions for its application and removal. The nursing coordinator developed instructions for providing passive range of motion exercises to his right arm, wrist and hand 3 times per day. The nursing assistants and Mr. V's wife have been instructed on how and when to apply and remove the hand splint and how to do the passive ROM exercises. These plans are documented on Mr. V's care plan. The total amount of time involved each day in removing and applying the hand splint and completing the ROM exercises is 30 minutes. The nursing assistants report that there is less resistance in Mr. V's affected extremity when bathing and dressing him. For both Splint or Brace assistance and Range of Motion (passive), **enter "7" as the number of days these nursing rehabilitative techniques were provided.**

Mrs. K was admitted to the nursing facility 7 days ago following repair to a fractured hip. Physical therapy was delayed due to complications and a weakened condition. Upon admission, she had difficulty moving herself in bed and required total assistance for transfers. To prevent further deterioration and increase her independence, the nursing staff implemented a plan on the second day following admission to teach her how to move herself in bed and transfer from bed to chair using a trapeze, the bedrails, and a transfer board. The plan was documented in Mrs. K's clinical record and communicated to all staff at the change of shift. The charge nurse documented in the nurses notes that in the five days Mrs. K has been receiving training and skill practice for bed mobility and transferring, her endurance and strength are improving, and she requires only extensive assistance for transferring. Each day the amount of time to provide this nursing rehabilitation intervention has been decreasing so that for the past five days, the average time is 45 minutes. **Enter "5" as the number of days training and skill practice for bed mobility and transfer was provided.**

Mrs. J had a CVA less than a year ago resulting in left-sided hemiplegia. Mrs. J has a strong desire to participate in her own care. Although she cannot dress herself independently, she is capable of participating in this activity of daily living. Mrs. J's overall care plan goal is to maximize her independence in ADL's. A plan, documented on the care plan, has been developed to teach Mrs. J how to put on and take off her blouse with no physical assistance from the staff. All of her blouses have been adapted for front closure with velcro. The nursing assistants have been instructed in how to verbally guide Mrs. J as she puts on and takes off her blouse. It takes approximately 20 minutes per day for Mrs. J to complete this task (dressing and undressing). **Enter "7" as the number of days training and skill practice for dressing and grooming was provided.**

(continued on next page)

Examples of Nursing Rehabilitation/Restoration (continued)

Using a quad cane and a short leg brace, Mrs. D is receiving training and skill practice in walking. Together, Mrs. D and the nursing staff have set progressive walking distance goals. The nursing staff has received instruction on how to provide Mrs. D with the instruction and guidance she needs to achieve the goals. She has three scheduled times each day where she learns how to apply her short leg brace followed by walking. Each teaching and practice episode for brace application and walking, supervised by a nursing assistant, takes approximately 15 minutes. **Enter "7" as the number of days for splint and brace assistance and training and skill practice in walking were provided**.

Experiencing a slow recovery from Guillain Barre syndrome, Mr. B is receiving daily training and skill practice in swallowing. Along with specially designed cups and appropriate food consistency, the documented plan of care to improve his ability to swallow involves proper body positioning, consistent verbal instructions, and jaw control techniques. Mr. B requires close monitoring when given food and fluids as he is at risk for choking and aspiration. Therefore, only licensed nurses provide this nursing rehabilitative intervention. It takes approximately 35 minutes each meal for Mr. B to finish his food and liquids. He receives supplements via a gastrostomy tube if he does not achieve the prescribed fluid and caloric intake by mouth. **Enter "7" as the number of days training and skill practice in swallowing was provided.**

Mr. W's cognitive status has been deteriorating progressively over the past several months. Despite deliberate nursing restoration, attempts to promote his independence in feeding himself, he will not eat unless he is fed. Because Mr. W did not receive nursing rehabilitation/restoration for eating in the last 7 days, **enter "0" as the number of days training and skill practice for eating was provided.**

Mrs. E has amyotrophic lateral sclerosis. She no longer has the ability to speak or even to nod her head "yes" and "no". Her cognitive skills remain intact, she can spell, and she can move her eyes in all directions. The speech language pathologist taught both Mrs. E and the nursing staff to use a communication board so that Mrs. E. could communicate with staff. The communication board has proven very successful and the nursing staff, volunteers and family members are reminded by a sign over Mrs. E's bed that they are to provide her with the board to enable her to communicate with them. This is also documented in Mrs. E's care plan. Because the teaching and practice in using the communication board had been completed two weeks ago and Mrs. E is able to use the board to communicate successfully, she no longer receives skill and practice training in communication. **Enter "0" as the number of days training and skill practice in communication was provided.**

P4. Physical Restraints (7-day look back)

Intent: To record the frequency, over the last seven days, with which the resident was restrained by any of the devices listed below at any time during the day or night. The intent is to evaluate as part of the assessment process whether or not a device meets the definition of a physical restraint, and then to code only those devices categorized in section P4 that have the effect of restraining the resident.

Definition: Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.

a. Full Bed Rails - Full rails may be one or more rails along both sides of the resident's bed that block three-quarters to the whole length of the mattress from top to bottom. This definition also includes beds with one side placed against the wall (prohibiting the resident from entering and exiting on that side) and the other side blocked by a full rail (one or more rails). Include in this category veil screens (used in pediatric units) and enclosed bed systems.

b. Other Types of Bed Rails Used - Any combination of partial rails (e.g., 1/4, 1/3, 1/2, 3/4, etc.) or combination of partial and full rails not covered by the above "full bed rail" category (e.g., one-side half rail, one-side full rail, two-sided half rails, etc.)

c. Trunk Restraint - Includes any device or equipment or material that the resident cannot easily remove (e.g., vest or waist restraint, belts used in wheelchairs).

d. Limb Restraint - Includes any device or equipment or material that the resident cannot easily remove, that restricts movement of any part of an upper extremity (i.e., hand, arm) or lower extremity (i.e., foot, leg). Include in this category mittens.

e. Chair Prevents Rising - Any type of chair with locked lap board or chair that places resident in a recumbent position that restricts rising or a chair that is soft and low to the floor. Include in this category enclosed framed wheeled walkers with or without a posterior seat and lap cushions that a resident cannot easily remove.

Process: Check the resident's clinical records. Consult nursing staff. Observe the resident. To determine whether or not an item is a physical restraint, the assessor should evaluate whether or not the resident can easily remove the device, material or equipment. If the resident cannot easily remove the item, continue with the assessment to determine whether or not the device meets the other provisions in the definition of a physical restraint. The assessor should not focus on the intent or reason behind the use of the device, but on the effect the device

has on the resident. Does the device, material, or equipment meet the definition of a physical restraint? If yes, code the item in the appropriate category.

Coding: For each device type, enter:

0. Not used in last 7 days

1. Used, but used less than daily in last 7 days

2. Used on a daily basis in last 7 days

Because the coding categories are limited, we have given some direction on which category to code particular devices. While the device may not be completely representative of the category description, follow the coding instruction as given. There may be devices that we have not given coding instructions for and there is not a category that is representative of the device. For those devices, do not code at this time, but note that in subsequent versions of the MDS, CMS will include an "other" category that would be an appropriate place to code these devices. **NOTE:** Any device, material or equipment that meets the definition of a physical restraint must have: a medical symptom that warrants the use of the restraint; a physician's order for use; and must be care planned whether or not there is a category to code the physical restraint on the MDS.

Exclude from this P4 section items that are typically used in the provision of medical care, such as catheters, drainage tubes, casts, traction, leg, arm, neck or back braces, abdominal binders and bandages that are serving in their usual capacity to meet medical need.

Clarifications:

- Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by restraints. It is vital that restraints used on this population be carefully considered and monitored. In some cases, the risk of using the device may be greater than the risk of not using the device.

- Should enclosed framed wheeled walkers, with or without a posterior seat, such as the Merry Walker® Ambulation Device and other devices like it, be coded in section P4e: "Chair prevents rising?"

  As will be set forth in the guidance to surveyors, the Merry Walker® Ambulation Device and similar devices should not be categorically classified as a restraint. The following coding information provides further detailed guidance on how to code utilization of the device that might for a particular resident be considered a restraint. If these devices assist ambulation for a particular resident, they should be coded as a cane/walker/crutch at Item G5a, whether or not they are coded as a restraint.